Legislative Testimony
Public Health Committee
HB5541 AAC Services Provided by Dental Professionals and Certification for Advanced Dental Hygiene Practitioner
Wednesday, March 21st, 2012
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Senator Gerratana, Representative Ritter and members of the Public Health committee, my name is Dr. Jonathan Knapp. I am an actively practicing family dentist in Bethel, who continues to accept new patients from the Connecticut Dental Health Partnership (aka HUSKY) program. I have served in various capacities at the local, state and national levels, and currently serve on the CSDA Access Committee and as the Local Arrangement Liaison for this year's Mission of Mercy Project in Danbury. I also serve as the Vice-Chair of the American Dental Association's Council on Dental Practice, which is charged with providing information and support for practitioners in all settings and at all career stages.

I am writing this testimony to express my objections to HB5541. For the last two years, the dentists of Connecticut have actively supported enactment of the Scope of Practice Review Process as proposed by the General Assembly's PRI Committee and finally enacted last year in PA11-209. The intent of that process is to gather evidence related to scope requests and synthesize that data into a report that objectively and clearly reflects the information received. The goal is to make technical issues and subtle nuances more understandable for you as legislators who cannot be expected to have granular level knowledge of each of the myriad of issues presented to you.

I commend the work of the committee that was assembled to process the information regarding Expanded Function Dental Assistants, Interim Therapeutic Restorations and Advanced Dental Hygiene Practitioners. It appears that there is universal support for EFDAs and ITR, with agreement that these both have a good track record and prospects for meaningful, safe and cost-effective improvements in access, and care delivery efficiencies. However, there seem to be disconnects between the evidence provided to the committee, what is contained in the DPH Report, and the provisions contained in this bill. There are some missing elements and things that are unclear in the resulting report, and HB5541 makes quantum leaps and assumptions that are not justified by evidence or the report. In fact, delving deeper into the ADHP proposal, beyond the tepid review published in the DPH report, paints an even more lackluster and disturbing picture of the implications of that model.

As an example from the DPH Executive Summary:

"In reviewing all of the information provided, the scope of practice review committee did not identify any specific public health and safety risks associated with allowing appropriately educated and trained dental hygienists to engage in expanded functions."

Is it possible that this statement reflects the fact that there is no data because the model, as proposed by CDHA and included in HB5541, does not exist and has not been evaluated? And how far will the expanded functions extend? HB5541 makes a quantum leap here. Nothing in the bill precludes ADHPs from performing extractions of permanent teeth on medically compromised or multiply medicated children, adults, or seniors. Additionally, the bill allows for diagnosis by ADHP's within those same populations who present with the most complicated, complex interactions between their oral health and their overall health.

Again, from the DPH Executive Summary:

"The ADHP model has also been compared to the Advanced Practice Registered Nurse (APRN), however there is still no national certification program for ADHP including competency examinations akin to those established for the APRN."

There are additional, very significant differences between ADHP's and APRN's. APRNs do not provide invasive, irreversible procedures – nothing akin to the extractions that would be permitted by HB5541, and the genesis of APRN's came as a means to address the fact that 80% of physicians are specialists. The reality is that 80% of dentists are primary care family practitioners. Only 20% pursue specialties. Particularly noteworthy is the fact that, given the anticipated effects of the Affordable Care Act, there will be the need for many more hygienists to practice in the traditional role as front line educators about proper oral health and nutrition, and providers of preventive oral health services.

"The ADHP model ... builds upon the education, training and experience of licensed dental hygienists who have been practicing for a minimum of two years and would require additional graduate level education and training... The dental therapist model creates a mid-level provider who does not necessarily have a dental background, has no clinical experience and would practice under the supervision of a dentist..."

Delving into these statements reveals some very key distinctions that actually detract from the ADHP and reflect favorably on the therapist model. At $50,000-60,000/year in tuition costs, the six years of training for an ADHP create a very expensive $300,000 model that can only be pursued by those who have those kinds of resources; those who will expect salaries higher than the average of $80,000-90,000 earned by hygienists in Hartford. These figures are not much lower than the compensation for newly graduated dentists. On the other hand, the shorter and less expensive training involved in becoming a therapist allows for much more culturally, and socio-economically diverse practitioners, with the cultural competence to provide more effective access to care.

And then there is the law of unintended consequences. The CT Dental Hygiene Association will state that more education is required and is pushing for expansion of scope into areas that should demand the education of a dentist. This will ultimately drive the costs of dental care higher as it will push the dental profession to follow the more expensive, specialized model that has occurred on the medical side. If you really want to implement a mid-level provider in our state, is ADHP the right way to do it?

That brings me to what may be the most important piece of this puzzle. Perhaps the greatest disconnect exists between the push to create a mid-level provider and the data from DSS demonstrating that Connecticut no longer has an access problem for our children.

So ultimately, with the disconnect between the lack of evidence in favor of ADHPs, and the blind leap that is the creation of that model in HB5541, the question becomes: Who is this legislation designed to benefit?

I offer my sincere thanks to the members of the Public Health committee for allowing me to submit this testimony. I urge you to oppose this bill. I am available to answer questions at your convenience.

Respectfully Submitted,

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